

# Cancer Among Hispanics and Latinos

## Introduction

The Hispanic/Latino population is often described as a mosaic of cultures. Moreover, the diversity extends to nationality, customs, heritage, lifestyles and socioeconomic status. The Hispanic heritage can be traced back to Spain. 'Latino/a' refers to persons living in Spanish-speaking Latin America and their heritage can be traced back to the Latin language. The terms 'Hispanic' and 'Latino/a' are used interchangeably in this report.

The Hispanic/Latino population comprises nearly 15% of the U.S. population and is the fastest growing racial/ethnic group. As of 2007, an estimated 2,400,500 Hispanic/Latinos reside in

the South Atlantic Division (SAD) and they make up 6.1% of the population.<sup>7</sup> The fastest population growth for Hispanics is in the South; Georgia, North Carolina and South Carolina are among the top states with an increase of more than 300% in the last ten years. Within the Division, the District of Columbia ranks highest in the proportion of Hispanic residents (8.7%), followed by Georgia at 7.5%, and West Virginia has the smallest proportion at 0.9%. (Table 1) Official census counts of the Hispanic/Latino population, however, are believed to be under-represented due to individual identity preference (black/white versus Hispanic/Latino) as well as legal status concerns of the community and recent changes in immigration patterns.

Overall, six out of ten Hispanic/Latino residents in the SAD have reported to be from Mexico, Puerto Rico or Cuba.<sup>8</sup> In North Carolina, Georgia and South Carolina, Mexicans comprise the majority of Hispanic residents, with 66.6%, 65.4% and 63.0%, respectively. Delaware has the largest proportion of Latinos of Puerto Rican descent (27.3%) and District of Columbia has the highest proportion from Cuba (4.9%). Persons from 'other Hispanic/Latino country' are most common in the District of Columbia (76.5%), Maryland (67.6%) and Virginia (61.3%). (Table 2)

Additional data reveal that the District of Columbia, with more than three-quarters of its population in the "other Hispanic/Latino" category, is home to the largest Bolivian population in the U.S., the second largest concentration of Salvadorans and significant populations from Peru, Colombia, Mexico, Guatemala, Honduras, Ecuador and Nicaragua. The District also includes embassies and consulates from many Latin American countries.

## Health Profile among Hispanic Adults

Experts believe that if current knowledge about cancer prevention and early detection were applied, at least half of all cancer deaths could be prevented. The American Cancer Society estimates that in 2008, about 170,000 cancer deaths will be attributed to tobacco use alone. In addition, approximately one-third (188,550) of the 565,650 cancer deaths expected in 2008 are attributable to poor nutrition, overweight/obesity and lack of physical activity. Cancer screening tests can detect pre-cancerous lesions, improve survival or decrease mortality by detecting cancer at an earlier stage when treatment is more effective.<sup>3</sup>

### *This report includes the following sections:*

- Health profile among Hispanic adults
- Health profile among Hispanic youth
- Cancer screening patterns
- Cancer incidence & mortality among Hispanics
- Stage at diagnosis and survival
- Access to care
- Programs to promote healthy behaviors among Hispanics
- Limitations

**Table 1. Percentage of Hispanic Residents by SAD State (ranked from highest to lowest)**

SAD State/District	Number of Hispanic Residents	Percent of Total State Population
District of Columbia	50,711	8.7%
Georgia	702,087	7.5%
North Carolina	598,562	6.7%
Delaware	54,319	6.3%
Virginia	487,057	6.3%
Maryland	340,026	6.0%
South Carolina	151,248	3.5%
West Virginia	16,490	0.9%
<b>South Atlantic Division</b>	<b>2,400,500</b>	<b>6.1%</b>

Source: Claritas

**Table 2. Distribution of Hispanic/Latino Residents by Country of Origin and SAD States, 2007 population estimates**

Country of Origin	DE	DC	GA	MD	NC	SC	VA	WV	SA*
Mexico	45.8%	12.8%	65.4%	19.1%	66.6%	63.0%	25.1%	40.0%	<b>49.3%</b>
Puerto Rico	27.3%	5.7%	7.4%	10.9%	7.5%	10.1%	10.9%	12.6%	<b>9.2%</b>
Cuba	1.7%	4.9%	2.7%	2.3%	1.8%	1.7%	2.7%	2.9%	<b>2.4%</b>
Other Hispanic/Latino	25.3%	76.5%	24.6%	67.6%	24.1%	25.2%	61.3%	44.5%	<b>39.1%</b>
<b>Total Known Hispanic/Latino Residents</b>	<b>54,319</b>	<b>50,711</b>	<b>702,087</b>	<b>340,026</b>	<b>598,562</b>	<b>151,248</b>	<b>487,057</b>	<b>16,490</b>	<b>2,400,500</b>

Source: Census; \*Population - weighted average.



**Tobacco Use:** The National Latino Council on Alcohol and Tobacco Prevention, more commonly known as LCAT, is a non-profit 501(c)(3) national organization established in 1989 in order to combat alcohol and tobacco problems and their underlying causes in Latino communities ([www.nlcatp.org](http://www.nlcatp.org)). As the only Latino national organization dedicated solely to reducing the harm caused by alcohol and tobacco in the Latino community, their work is conducted through research, advocacy, policy analysis, community education, training and information dissemination.

Results of their research show that:

- Puerto Ricans are more likely than other Latinos to be current smokers.
- For Latinas, there is a positive relationship between level of acculturation and smoking.
- In 2005, 22 percent of Hispanic high school students smoked, a 19 percent increase over the 2003 smoking rate of 18.4 percent.
- In 2004, 9.4 percent of Hispanic middle school students smoked.
- Puerto Rican women are nearly twice as likely to smoke as women of other Hispanic groups.
- Lung cancer is the leading cause of cancer deaths among Latinos living in the United States.

The Behavioral Risk Factor Surveillance System survey (BRFSS) is an annual survey of the Centers for Disease Control and Prevention (CDC) and the U.S. states and territories.<sup>6</sup> Although the state-specific data on risk behaviors among Hispanics are

limited, smoking patterns among Latinos in the South Atlantic Division do generally follow the national pattern where 17.9% of Hispanics are current smokers in 2007, compared with 19.8% non-Hispanic (NH) white and 21.7% non-Hispanic (NH) blacks. An exception is noted in Delaware, where the cigarette smoking rate among Hispanics (24.3%) is higher than among non-Hispanic whites (19.4%) and non-Hispanic blacks (14.6%). (Table 3)

Smoking rates among Hispanic men are about 25% lower than in non-Hispanic white men, and Hispanic women are about half as likely to smoke as non-Hispanic white women.<sup>6</sup> Cigarette smoking rates among Hispanics born in the U.S. are higher than among those born elsewhere.<sup>2</sup>

Poor nutrition, lack of physical activity and being obese or overweight are major cancer risk factors, second only to tobacco use. Approximately one-third, or 188,550 of the 565,650 cancer deaths in 2008 will have been associated with these three risk factors. This statistic would mean that 7,772 of the 23,320 U.S. cancer deaths expected among Hispanics in 2006 could have been prevented through a healthy diet, regular physical activity and weight control.

**Nutrition and Physical Activity:** The ACS Recommendations for Nutrition and Physical Activity, updated in 2006, highlight the importance of having a healthy weight and physical activity in the prevention of cancer.<sup>5</sup> The recommendations include the following:

Maintain a healthy weight throughout life.

- Balance calorie intake with physical activity.
- Avoid excessive weight gain throughout life.
- Achieve and maintain a healthy weight if currently overweight or obese.

Adopt a physically active lifestyle.

- *Adults:* Engage in at least 30 minutes of moderate to vigorous physical activity, above usual activities, on 5 or more days of the week; 45 to 60 minutes of intentional physical activity are preferable.
- *Children and adolescents:* Engage in at least 60 minutes per day of moderate to vigorous physical activity at least 5 days per week.

**Fruits and Vegetables:** Eating five or more servings of a variety of vegetables and fruits every day is a recommendation in the American Cancer Society's Nutrition Guidelines, updated in 2006.<sup>5</sup> Unfortunately, BRFSS estimates show that more than three-quarters of adult Americans DO NOT meet the ACS rec-

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**Table 3. Estimated Prevalence of Current Cigarette Smoking among Adults (%) by Race/Ethnicity for SAD States and U.S., 2007**

	DE	DC	GA	MD	NC	SC	VA	WV	SA*	US
Hispanic	24.3	11.0	15.0	13.9	19.2	19.6	14.1	n/a	17.9	16.7
NH White	19.4	8.5	19.1	17.4	23.1	22.0	18.1	27.1	19.2	19.8
NH Black	14.6	24.2	19.6	19.0	23.0	24.7	20.9	31.6	20.8	21.7

Source: BRFSS; \* Population-weighted estimated average of SAD states with available data

ommendation for minimum fruit and vegetable consumption. In the SAD, consumption is lowest among Hispanics (79.5%), followed by NH whites (77.8%) and NH blacks (76.3%). (Table 4)

**Physical Activity:** Research indicates that regular physical activity can prevent cancer by helping reduce overweight and obesity. Achieving and/or maintaining an ideal weight can help decrease the risk of cancers of the colon/rectum, breast (premenopausal), uterus and prostate. Regular physical activity is also beneficial in the prevention of chronic diseases, particularly diabetes and heart disease. The BRFSS question “do you have at 30+ minutes of moderate physical activity five or more days per week, or vigorous physical activity for 20+ minutes three or more days per week?” is the measure of adult physical activity that most closely resembles the ACS guideline listed above.

The South Atlantic Division overall has a higher prevalence than the U.S. of persons that DO NOT have regular physical activity in each of the race/ethnicity groups shown in Table 5. The rate of physical inactivity among Hispanics in the SAD is 18% higher than the U.S. Hispanic rate, but data are only available for the District of Columbia, Maryland and North Carolina. In North Carolina and South Carolina, prevalence of physical inactivity is higher than the U.S. among both white and black non-Hispanics.

**Obesity/Overweight:** Being overweight or obese is associated with increased risk of cancers of the breast, prostate, colon/rectum and uterus, in addition to other chronic diseases such as diabetes, high blood pressure, heart disease and premature death. A common measure to establish whether a person is un-

derweight, normal weight, overweight or obese is the Body Mass Index (BMI) which is determined by the person's height and weight. Obese is having a BMI of 30 or higher and overweight is defined as having a BMI of 25 to less than 30.

Obesity has been increasing in the U.S. in both Hispanics and non-Hispanics. Data from the BRFSS survey, where overweight and obese are classified based on the individual's self-reported height and weight, show that in the U.S. nearly 68 percent of Hispanic residents were overweight or obese compared with 61.7% of non-Hispanic whites. Non-Hispanic blacks, however, had an obesity/overweight prevalence of 72.6%. Data from other surveys suggest that the rate of obesity is higher among Puerto Ricans and Mexicans than in other Hispanic subgroups.<sup>2</sup>

In the South Atlantic Division, the prevalence of overweight/obesity among non-Hispanics is similar to the U.S. rate. An exception is the District of Columbia, where the prevalence of overweight/obesity for NH whites at 39.3% is 36% lower than the U.S. rate for that race/ethnic group. Although data for Hispanics are only available for 2 states and the District of Columbia, the SA combined rate (60.7%) is lower than the U.S. and lower than NH whites and NH blacks in the SA Division; 62.8% and 72.7%, respectively. (Table 6)

## Health Profile among Hispanic Youth

The Youth Risk Behavior Surveillance Survey (YRBSS) is an annual survey that is also conducted by the Centers for Disease Prevention and Control.<sup>13</sup> Although the data on Hispanic youth are limited at the state level, data for the entire U.S. can provide

**Table 4. Estimated Prevalence of Not Eating 5 Fruits & Vegetables per Day (%) among Adults by Race/Ethnicity for SAD States and U.S., 2007**

	DE	DC	GA	MD	NC	SC	VA	WV	SA*	US
Hispanic	80.5	71.2	78.6	79.6	85.3	81.5	75.8	n/a	79.5	75.3
NH White	79.3	64.7	75.2	72.9	76.9	80.9	73.5	80.9	77.8	75.5
NH Black	77.1	69.5	74.8	74.8	81.5	82.3	72.9	75.7	76.3	76.9

Source: BRFSS; \* Population-weighted estimated average of SAD states with available data

**Table 5. Estimated Lack of Physical Activity (%) among Adults by Race/Ethnicity for SAD States and U.S., 2007**

	DE	DC	GA	MD	NC	SC	VA	WV	SA*	US
Hispanic	n/a	56.2	n/a	60.2	69.0	n/a	n/a	n/a	65.2	55.3
NH White	50.1	33.3	50.9	48.4	53.1	51.7	49.0	54.5	50.6	48.4
NH Black	61.8	54.7	57.3	58.7	62.3	60.0	56.7	n/a	59.0	58.6

Source: BRFSS; \* Population-weighted estimated average of SAD states with available data

**Table 6. Estimated Prevalence of Overweight/Obesity among Adults (%) by Race/Ethnicity for SAD States and U.S., 2007**

	DE	DC	GA	MD	NC	SC	VA	WV	SA*	US
Hispanic	57.0	57.2	63.5	56.8	62.4	58.3	56.2	n/a	60.7	67.7
NH White	64.2	39.3	63.2	60.7	62.5	63.0	60.3	68.6	62.8	61.7
NH Black	73.0	68.8	69.9	74.2	74.7	73.6	72.4	55.0	72.7	72.6

Source: BRFSS; \* Population-weighted estimated average of SAD states with available data



**Table 7. Estimated Prevalence of Risk Behaviors among High School Students (%) by Race/Ethnicity for the U.S., 2007**

Risk Factor	Hispanic		White Non-Hispanic		Black Non-Hispanic	
	Male	Female	Male	Female	Male	Female
Current Cigarette Smoking	18.7	14.6	23.8	22.5	14.9	8.4
Current Smokeless Tobacco Use	6.7	2.7	18.0	2.5	2.0	0.5
Did Not Consume 5 Fruits & Vegetables per Day	74.1	77.9	79.9	82.4	73.4	76.6
Did Not Meet Recommended Level of Physical Activity	18.8	35.2	16.7	28.2	21.8	42.1
Are Overweight or Obese	38.6	30.6	30.3	19.6	35.5	39.2

Source: YRBSS, 2007

an invaluable profile of risk behavior patterns among Hispanic students. (Table 7) Data are shown here for high school students.

**Cigarette Smoking:** Data from the YRBSS 2007 show that the prevalence of cigarette smoking among white NH youth (23.8% male and 22.5% female) is still higher than among Hispanic youth (18.7% male and 14.6% female). (Table 7) Among black non-Hispanic students, 14.9% of male and 8.4% of female students reported current cigarette use (at least one cigarette per day over the past 30 days). Although Hispanic youth in the U.S. tend to smoke less than NH youth, these patterns may change as marketing efforts increase in Latin American countries, particularly among women, and also target Hispanic women and youth in the United States.<sup>2</sup>

**Smokeless Tobacco Use:** Smokeless tobacco products, including chewing tobacco and snuff, are not safe substitutes for cigarette smoking. These products can cause oral and pancreatic cancers, noncancerous oral conditions and can lead to nicotine addiction. The tobacco industry continues to market new and existing products as supplemental sources of nicotine in smoke-free settings and misleadingly markets these products as a low-risk option for smokers who are unable to quit.



In Table 7 are usage rates for smokeless tobacco products among high school students. Among Latinos, 6.7% of male and 2.7% of female students used smokeless tobacco products. The highest prevalence rate was 18.0% of white NH youth using smokeless tobacco products and the lowest rate was 0.5% among black non-Latinas. In each race/ethnicity category in Table 7, male students are more likely than female students to be users of smokeless tobacco products.

**Fruits and Vegetables:** ACS recommendations on fruit and vegetable consumption for children/youth parallel those for adults. Among male students, the prevalence of not eating 5 or more fruits and vegetables was highest among white NH (72.2%) than Hispanic (76.0%) and black NH (75.1%). In each race/ethnicity category, female students ate more fruits and vegetables daily than male students, although the difference was only about two percentage points in each category. (Table 7)

**Physical Activity:** The recommended physical activity for children and adolescents is to engage in at least 60 minutes per day of moderate to vigorous physical activity at least 5 days per week. In each race/ethnicity category, the prevalence of students who DO NOT meet the recommended physical activity level is higher among female than male students. Among male students, 18.8% of Hispanics did not meet the physical activity requirements; black non-Hispanics had the highest rate (21.8%) and white non-Hispanics the lowest rate at 16.7%. A similar pattern is seen among female students. (Table 7)

**Overweight/Obesity:** Since 1990, the prevalence of overweight children has increased sharply in children of all racial and ethnic groups in the U.S. Overweight children often become overweight adults, with increased risks of poor health outcomes such as high blood pressure, high cholesterol and diabetes.<sup>3</sup> In Table 7 are prevalence rates for overweight/obese by gender and ethnicity/race category. As in adults, the weight category for children is determined by the Body Mass Index (BMI), but the formulas for the childhood BMI vary by age. Among male youth, the rate of being overweight/obese is highest among Hispanic high school students (38.6%), followed by non-Hispanic black (35.5%) and NH white (30.3%) high school students. Among female high school students, non-Latina blacks have the highest rate of overweight (39.2%), followed by Latinas (30.6%) and non-Latina white high school students (19.6%).

## Cancer Screening Patterns among Hispanics

Cancer screening as recommended by the American Cancer Society (ACS) can measurably improve one's chances for a favorable outcome by detecting the cancer at an early stage when treatments are most effective. These guidelines are for people at average risk for cancer (unless otherwise specified) and without any

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specific symptoms. Those that are at increased risk for certain cancers should consult their physician as they may need to follow a different screening schedule, such as starting at an earlier age or being screened more often. Also, persons with symptoms that could be related to cancer should see their doctor right away.<sup>4</sup>

**Breast Cancer Screening:** The ACS guidelines state that yearly mammograms are recommended starting at age 40 and continuing for as long as a woman is in good health.<sup>2</sup> A mammogram is a low-dose X-ray procedure that can detect breast cancer at an early stage when treatment would be more effective. In 2006 in the South Atlantic Division, Latinas have a lower rate of mammography screening (60.7%) than non-Latina whites (62.8%) and non-Latina blacks (63.8%). (Table 8) Additional survey data from 2003 show that women from Central and South America, and Cuba have higher mammography screening rates than Mexican women.<sup>2</sup>

U.S. data show a screening pattern that is similar to the SAD, but the U.S. screening rate in each race/ethnicity group is 1-2 percentage points lower than seen in the SAD. Although the mammography screening rates among Latinas have improved considerably during the past 20 years and are approaching those of non-Latinas, breast cancers diagnosed among Latinas are, on average, diagnosed at a more advanced stage than those diagnosed among non-Latinas.<sup>2</sup>

**Prostate Cancer Screening:** The ACS suggests screening for prostate cancer by a combination of the prostate-specific antigen (PSA) test and digital rectal exam (DRE) at ages and time intervals that are dependent upon each man's race, age and

known risk factors.<sup>5</sup> The BRFSS questionnaire asks men ages 40 and older if they "have had a PSA (prostate-specific antigen) test within the past two years." In the U.S., Hispanic men have the lowest PSA screening rate (43.0%), followed by NH black men (48.1%) and NH white men (55.6%). Non-Hispanic men in the SA Division follow the same pattern as U.S. men. In fact, PSA screening rates are lower for black NH men than white NH men in each state in the South Atlantic Division, most notably in Delaware and South Carolina. (Table 9)

**Colorectal Cancer Screening:** New screening guidelines for colorectal cancer released in March 2008 include: (1) tests that find polyps and cancer and (2) tests that mainly find cancer and are shown in detail on page 82 of this publication.<sup>5</sup> The BRFSS questionnaire asks adults ages 50+ if "they have ever had a sigmoidoscopy or colonoscopy" (i.e. an endoscopy) (Table 10). Although the new guidelines recommend a flexible sigmoidoscopy every 5 years or a colonoscopy every 10 years, the BRFSS question can still be used to approximate regional as well as sex- and race/ethnicity-specific screening patterns across the SAD.

The rate of screening by endoscopy among South Atlantic Division residents ages 50+ is higher than that seen for the U.S. in each race/ethnicity category. (Table 10) Although Hispanic adults have the lowest screening rates of the three race/ethnicity groups, their screening rate in the SAD (49.2%) is nearly one-third higher than that among U.S. Hispanics (38.2%). Maryland has the highest screening rate for Hispanics (64.3%), followed by Georgia with 55.2% screened. Among non-Hispanic whites, the District of Columbia and Delaware have the highest screening

**Table 8. Estimated Mammography Screening Rates among Women Ages 40+ by Race/Ethnicity for SAD and U.S., 2006**

	DE	DC	GA	MD	NC	SC	VA	WV	SA*	US
Hispanic	n/a	n/a	60.7	67.2	52.6	56.3	74.0	n/a	60.7	58.7
NH White	68.9	62.0	63.3	63.1	64.1	56.4	63.3	62.4	62.8	61.6
NH Black	77.8	64.7	67.8	65.3	66.1	61.0	55.1	n/a	63.8	62.7

Source: BRFSS; \* Population-weighted estimated average of South Atlantic states with available data

**Table 9. Estimated Prostate Cancer Screening (PSA) Rates (%) for Men Ages 40 + by Race/Ethnicity for SAD and U.S., 2006**

	DE	DC	GA	MD	NC	SC	VA	WV	SA*	US
Hispanic	n/a	n/a	n/a	n/a	32.1	n/a	n/a	n/a	n/a	43.0
NH White	63.6	57.2	56.7	58.0	57.7	57.3	55.0	54.0	56.9	55.6
NH Black	43.5	50.0	49.9	46.9	50.4	41.2	53.7	n/a	49.2	48.1

Source: BRFSS; \* Population-weighted estimated average of South Atlantic states with available data

**Table 10. Estimated Colorectal Cancer Screening (endoscopy) Rates (%) for Adults Ages 50 + by Race/Ethnicity for SAD and U.S., 2006**

	DE	DC	GA	MD	NC	SC	VA	WV	SA*	US
Hispanic	n/a	n/a	55.2	64.3	41.1	51.8	38.7	n/a	49.2	38.2
NH White	61.7	62.7	50.5	57.7	54.2	51.4	58.4	46.1	54.2	51.5
NH Black	59.3	55.4	47.3	58.4	52.3	43.0	59.3	n/a	52.5	49.3

Source: BRFSS; \* Population-weighted estimated average of South Atlantic states with available data

rates at 62.7% and 61.7%, respectively. Non-Hispanic blacks have the highest screening rates in Delaware and Virginia (both at 59.3%).

The BRFSS survey also asks adults ages 50+ if “they have had a blood stool test within the past two years.” (Table 11) The blood stool test, often referred to as the Fecal Occult Blood Test or FOBT, is also one of the tests recommended in the ACS guidelines. Hispanics have the lowest frequency of FOBT screening of the race/ethnic groups in the U.S. (11.3%) and in the SAD (10.9%). The FOBT rate among NH blacks is higher than or equal to the rate for NH whites in each South Atlantic Division state.

**Cervical Cancer Screening:** The ACS suggests screening for cervical cancer by Pap tests at time intervals that are dependent upon the woman’s age, risk factors and sexual history.<sup>5</sup> The BRFSS questionnaire measures cervical cancer screening by the question “have you had a Pap test within the past 2 years?” for women ages 18 and older. Although Latinas have been less likely to participate in cervical cancer screening, their rates have improved in recent decades. Among Latinas, cervical cancer screening rates are lowest among Mexican women and among uninsured women.<sup>2</sup>

Latinas have the lowest cervical cancer screening rates in the South Atlantic Division (82.8%) as well as the U.S. (82.0%). In Delaware, however, the rate for Latinas is higher than that for non-Latinas, but the opposite is true (higher among non-Latinas than Latinas) in the District of Columbia, Georgia, Maryland and North Carolina. (Table 12)

## Cancer Incidence and Mortality among Hispanics

About 39,940 new cancer cases in Hispanic men and 42,140 cases in Hispanic women were expected to be diagnosed in the U.S. in 2006. The most commonly diagnosed cancers among Hispanic men were expected to be prostate (30%), colon/rectum (11%) and lung (8%). Among Latinas, the most common cancers were expected to be breast (34%), colon/rectum (9%) and lung (6%).<sup>2</sup>

### Cancer Incidence:

State-specific data on cancer incidence and mortality have not been published by South Atlantic Division state cancer registries due to the relatively small numbers of Hispanic residents in each state. Data for the United States, however, show that Hispanics have 30% lower incidence rates

for all cancers combined when compared to whites, but Latinos generally have higher rates of cancers associated with certain infections, such as cancers of the uterine cervix, liver, gallbladder and stomach.<sup>2</sup> Hispanic men and women are 1.5 to 2 times more likely to have one of these four cancers than non-Latinos.

**Cancer Mortality:** The numbers of cancer deaths in 2006 were expected to be 12,320 among Hispanic men and 11,000 in Latinas in the U.S. In Hispanic men, lung cancer would account for 21% of the deaths, followed by colon/rectum (11%) and prostate (9%). Among Latinas, breast cancer is the leading cause of cancer death (21% expected), followed by lung (9%) and colon/rectum (6%). This pattern is in contrast with white non-Hispanic women, among whom lung cancer is the most common cause of cancer death.

**Childhood Cancer:** Cancer is relatively rare among children (0-14 years) and adolescents (15-19 years), and the types of cancers found in children/adolescents are different from those seen in adults. It was estimated that 1,850 Hispanic children would be diagnosed with cancer in the U.S. in 2006. The prevalence of child/adolescent cancers in Hispanics (2.3% of all cancers) is higher than that seen in the total U.S. population, where only 1%

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Table 11. Estimated Fecal Occult Blood Test Rates (%) for Adults Ages 50 + by Race/Ethnicity for South Atlantic Division and U.S., 2006

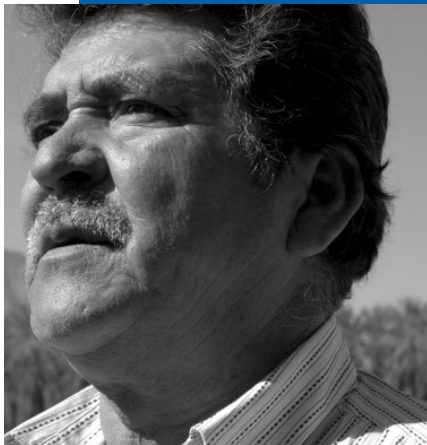
	DE	DC	GA	MD	NC	SC	VA	WV	SA*	US
Hispanic	n/a	n/a	11.0	23.3	9.5	12.6	2.4	n/a	10.9	11.3
NH White	14.4	22.5	17.3	18.6	21.1	13.5	14.7	18.4	17.5	16.5
NH Black	16.1	22.5	19.8	21.1	21.1	17.6	15.9	n/a	19.2	16.9

Source: BRFSS; \* Population-weighted estimated average of SAD states with available data

Table 12. Estimated Pap Smear Screening Rates by Race/Ethnicity Among Women Ages 18+ for SAD and U.S., 2006

	DE	DC	GA	MD	NC	SC	VA	WV	SA*	US
Hispanic	91.3	86.6	75.3	82.2	83.9	87.2	87.5	n/a	82.8	82.0
NH White	89.4	90.3	87.6	87.7	86.3	85.7	85.3	83.6	86.5	84.2
NH Black	86.8	88.6	90.3	88.5	89.6	90.3	89.2	n/a	89.5	87.2

Source: BRFSS; \* Population-weighted estimated average of SAD states with available data





of cancers are childhood cancers. One reason is that the U.S. Hispanic population is younger on average than the rest of the U.S. population; children account for 34% of the Hispanic population compared to 25% of the total U.S. population.<sup>2</sup> It was estimated that 350 Hispanic children would die from cancer in 2006.

Latinos are affected by many economic and cultural disparities in health care, including a disproportionate lack of participation in federally-funded cancer research. Their lack of inclusion in health research had hindered the development of prevention guidelines and treatments appropriate for this special population group. Among Latinos, inadequate screening and preventive care often lead to late diagnosis, delayed and/or inadequate treatment and, with some cancers, higher mortality. The inequalities seen in cancer incidence and mortality between Latino and non-Latino populations can be reduced by eliminating exposure to infectious agents that cause cancer, preventing Hispanics from adopting traditionally-avoided high risk cancer behaviors, increasing use of effective clinical preventive behaviors and assuring that every person diagnosed with cancer has affordable and timely access to state-of-the-art, affordable cancer care.<sup>10</sup>

## Stage at Cancer Diagnosis and Survival

Stage at diagnosis indicates whether or not the cancer has spread to other organs and regions of the body and is one of the tumor characteristics that is used to select a treatment for the patient. In general, cancers diagnosed in the later stages (regional and distant) have a poorer prognosis because the tumor has spread beyond the site of origin.

Health care barriers such as lack of health insurance or a usual source of care are experienced by many Hispanic men and women in the U.S., as reflected in their lower rates of cancer screening as well as other preventive behaviors. One example of the effects of lack of access to care can be seen for female breast cancer.

Breast cancer is the leading cancer among women in the United States, representing 32% of all cancer cases among women. It is estimated that 1 in 7 women will develop breast cancer during their lifetime. Although breast cancer incidence rates are lower among Latinas compared to non-Latinas, Latinas are more frequently diagnosed at a later stage of breast cancer than non-Latinas.

### Stages At Diagnosis

**In Situ** refers to a neoplasm that is “noninvasive” and confined to a small area within the tissue of origin

**Localized** is an invasive malignant cancer confined entirely to the organ of origin

**Regional** is a cancer that 1) extends beyond the limits of the organ of origin into surrounding organs/tissues or 2) involves regional lymph nodes by way of lymphatic system

**Distant** indicates that the cancer has spread to other parts of the body, such as the lungs, liver, brain or to distant lymph nodes.

nas. Data for the U.S. below show that for female breast cancers diagnosed during 2000-2003, only 54% of Latinas compared with 63% of non-Latinas were diagnosed in the local stage. (Chart 1) Latinas are also more likely to be diagnosed with larger breast tumors than non-Hispanic women.

In addition, National data show that Hispanic men diagnosed with prostate cancer are 3.7 times more likely to be diagnosed at a later stage than non-Latinos.<sup>2</sup>

A cancer survival rate indicates the percentage of patients who are alive for a given time period, usually five years, after a diagnosis of cancer. SEER data show that Hispanic men and women have lower survival rates for most cancers, even after adjusting for difference in age and stage distribution. For example, a Hispanic man diagnosed with stomach cancer is 26% more likely to die from stomach cancer during the five years after diagnosis compared to a non-Hispanic white man of the same age and same stage at diagnosis. SEER data show that five-year survival from breast cancer for Latinas during 1992-2000 was only 83.0% compared to 87.5% for non-Latinas. In addition, when survival is adjusted for stage and age at diagnosis, Latinas were 22% more likely to die from breast cancer than white non-Latinas.<sup>2</sup> These differences may reflect poorer access to timely, adequate health care.

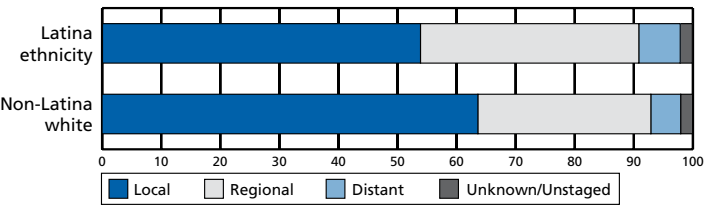
## Access to Care

Health disparities have long been documented among Latinos and other special ethnic and/or racial minority groups in the U.S. Research studies, however, consistently show that when patients from ethnic and racial minority groups receive the same quality of health care as non-Hispanic whites, for example, their health outcomes are very similar.

Although the Spanish language is the second most common language in the U.S. and the Nation has the fifth largest Spanish-speaking population in the world, language barriers prevent many Latinos from understanding information from a doctor’s office or instructions for prescription medicine. Lack of culturally-appropriate services adds to barriers for Hispanics to access adequate health care services and for them to be able to navigate successfully through the complex health care system. In addition, Hispanics in the U.S. are less likely to have health insurance coverage than non-Hispanics.<sup>2</sup>

The Hispanic population comprises 15% of the U.S. population but Hispanics make up 31.3% of the Nation’s uninsured.<sup>11</sup> Data from the 2007 BRFSS survey show that when asked ‘Do you have

**Chart 1. Stage at Diagnosis of Female Breast Cancer Cases for Latinas and White Non-Latinas, U.S., 2000-2003**



any usual source of health care coverage?', Hispanics are more likely to answer 'no' than non-Hispanics. In the SAD, sparse data from the BRFSS also show that the proportion of adults without any usual source of health care coverage is markedly higher among Hispanic (58.9%) than non-Hispanic whites (12.7%) and blacks (22.8%). (Table 13) Although data are limited to three states, the weighted average of these states estimates that 58.9% of South Atlantic Division Hispanics do not have access to health care, compared to 43.3% for the U.S. In the SAD, 12.7% of non-Hispanic whites and 22.8% of non-Hispanic blacks do not have a usual source of health care coverage compared with 13.0% and 22.9%, respectively, for the U.S.

### Several measures of disparities among Hispanics are<sup>9</sup>:

#### Demographics:

- Hispanics/Latinos (H/L) are twice as likely to live in poverty as white non-Hispanics (WN-H).
- H/L have a median income that is 39% lower than WN-H and one-third lower than the national average
- H/L have lower rates of educational attainment than WN-H; only 57% of H/L have completed a high school education compared with 89% of W-NH

#### Health Status:

- 51% of H/L compared with 65% of WN-H and 51% of BN-H report their health status as fair or poor.

#### Access to Health Care:

- H/L are 2.5 times more likely to report not having a doctor than WN-H. This disparity holds even when controlling for income and insurance status.
- H/L are more likely (54%) than WN-H (43%) and BN-H (44%) to go without needed care.
- H/L are most likely to use a community health center, as their usual place of care (21% vs. 9% WN-H).

#### Health Insurance Coverage:

- H/L are three times more likely to lack health insurance coverage than NH-W (35% H/L vs. 12% WN-H). Even at high income levels, Hispanics are more likely to be uninsured.
- Nearly half of Hispanics report being uninsured at some point in the past year.
- H/L are least likely to have continuous insurance coverage even when a family member has full-time employment (53% H/L vs. 82% WN-H).

#### Quality Care (in addition to cancer screening patterns):

- H/L (140/1,000 discharges with complications), along with Asian/Pacific Islanders (155/1,000), are more likely to die

from complications in hospital care than WN-H and BN-H (both 133/1,000).

- Hispanics (55%) and Asians (54%) are less likely to get a same day or next day appointment than WN-H (66%), and more likely to wait six days or longer to see a doctor (26% H/L and 18% Asian compared with 14% WN-H and 19% BN-H).
- Hispanics and Asians are less likely to understand their doctor and less likely to feel their doctor listened to them than WN-H and BN-H.
- H/L are twice as likely as WN-H to leave the doctor's office with unasked questions.

### Programs to Promote Healthy Behaviors among Hispanics

The lack of access to health care among Hispanics as well as other disadvantaged populations can adversely affect cancer incidence and mortality throughout the cancer spectrum, from cancer prevention and early detection to treatment, survivorship and palliative care. Studies have shown, however, that social support offered in local outreach programs and culturally-appropriate interventions will help increase participation in these services. Lay Hispanic health advisors, along with physician encouragement, are an effective strategy to improve participation in cancer screening as well as prevention initiatives.<sup>2</sup>

Numerous Hispanic outreach programs have been active or are in various phases of development in the South Atlantic Division. Below are just a few examples of such programs designed to improve access to care among Hispanics and help improve the overall health among Latinos in the SAD. Dedicated staff members for Hispanic outreach are strategically placed in regions with the highest Hispanic population. The SAD has hired bilingual and/or bicultural staff employed in key positions, including community outreach to specific populations, patient navigation, and Cancer Resource Network information specialists. In some instances, the South Atlantic Division was able to influence, and in some cases, provide funding for hiring of full time staff dedicated to Hispanic/Latino Outreach: Hispanic Partnerships Project Manager, Hispanic Outreach Project Manager, Bilingual Mission Delivery Manager and Mission Delivery Manager.

#### I. *Promotores de Salud - Promoters of Health*

*Promotores de Salud (Promoters of Health)* are often referred to as Community Health Advisors or Community Health Workers. These terms are used interchangeably

*Continued*

	DE	DC	GA	MD	NC	SC	VA	WV	SA*	US
Hispanic	n/a	22.2	n/a	53.5	64.7	n/a	n/a	n/a	58.9	43.3
NH White	8.5	2.4	14.1	8.6	15.1	14.2	10.0	20.6	12.7	13.0
NH Black	8.5	12.7	28.2	15.8	25.4	27.8	17.8	n/a	22.8	22.9

Source: BRFSS; \* Population-weighted estimated average of SAD states with available data





here with the acknowledgement that cultural nuances exist between Promotores and *Community Health Worker (CHW)* programs. The Promotores are members of a community who provide education and other assistance to fellow community members so that their health needs may be met. They each use their unique strengths of their own experience and cultural background to provide health education, help others navigate through health care systems, provide support as needed so that others may access information and needed care, monitor vital signs and/or advise on self-management of chronic diseases. Although Promotores have traditionally performed their duties in an advocacy role without pay or with a small stipend and perhaps some support services, such as providing a place to keep records and materials, they can also be paid for their work.

- A. Baltimore City, MD:** One example of Promotores in the South Atlantic Division is the Latino Provider Network that works for the rights of Latinos through (1) exchange of information among providers and (2) advocacy and education to Latinas in the City of Baltimore. The primary objective is to promote early detection, prevention and successful treatment of breast and cervical cancer using Promotoras de Salud. These women disseminate breast and cervical cancer education materials and information on where to obtain free or low-cost breast and cervical cancer screening to the Latina community in Baltimore.
- B. South Carolina:** A second Promotores program in the SAD is called the Partnership for Cancer Prevention – Latino/a Initiative in South Carolina. The objectives of the Initiative are to: (1) promote access to cancer prevention and early detection health services among Hispanics in South Carolina who are not proficient in English through the development of resources that can be used by members of the partnership, cancer control agencies and healthcare providers within the South Atlantic Division, (2) to promote partnership activities and increase community awareness of cancer prevention and control resources by developing and

implementing a coordinated health communication campaign targeting the Hispanic community in the greater Columbia area and (3) recruit and train four Promotoras on use of the adapted Spanish Cancer Education Guide and have them deliver cancer educational sessions to groups of ten Spanish-speaking Hispanics. Promotoras will also distribute the Su Salud newsletters and promote activities of the Partnership for Cancer Prevention in their communities.

## **II. Ventanilla de Salud (VDS) - Health Window**

The *Ventanilla de Salud (VDS)* or *Health Window* program is a partnership among local health advocacy and health service organizations and the Mexican consular network. This partnership is led by local United States 501(c)3 service agencies with the appropriate administrative capacity and technical expertise to manage and implement the program. The Institute of Mexicans Abroad (IME), a division of the Secretary of Foreign Affairs of Mexico, has established VDS program guidelines and officially promoted the development of this program since 2004.

The American Cancer Society is currently in partnerships with the Mexican consulates in the District of Columbia; Raleigh, North Carolina and Atlanta, Georgia.

The VDS Program Objectives are (1) to provide personal and culturally sensitive counseling and referral services onsite to consular clients and their families on how to access available health services in both countries, (2) when necessary and appropriate, provide backup legal advocacy to consular clients on health-related issues such as enrollment in public health insurance programs and establishing medical homes, (3) to educate and inform consular clients on health issues and prevention topics relevant to their community and their specific needs and (4) to build a close, direct partnership linkage of client referral and health education among local Mexican consulates, local health departments, community health organizations and the major health institutions in Mexico.

VDS or *Health Windows* incorporates bilingual, bicultural and highly trained health educators and health advocates into the regular flow of consular services to provide on-site assessment, referral and linkage to available health services. Advocates assess consulate clients for eligibility for government-funded health insurance and for other primary care services, facilitated by a tool called *Guide to Health Programs*. In addition, health educators conduct 15 to 30 minute consumer education sessions for a large number of persons per day. The educational presentations include an array of important public health and health care access topics. Materials such as Public Service Announcements and short health education videos are often used to enhance the presentations.

### III. *Estacion de Salud y Servicios de El Consulado de El Salvador - Health and Services Station of the Salvadoran Consulate*

The Hispanic Institute for Blindness Prevention (HIBP) is a non-profit organization (status 501©(3)) whose mission is to contribute to lowering the risk of blindness by focusing on underserved families, minorities and other groups who are more likely to be at risk of eye-related diseases. Since November 2005, HIBP has partnered with the Salvadoran Consulate and other local and federal agencies to create and implement a Program called “*Estacion de Salud y Servicios de El Consulado de El Salvador*” (*Health and Services Station of the Salvadoran Consulate*). HIBP is the leading agency for this program in both the Consulates of El Salvador in Washington, D.C. and Woodbridge, VA. The goal of this partnership is to help overcome barriers such as language, education, opportunity and income that limit access to existing health programs, community health resources and public health insurance programs.

The *Salvadoran Consulate Program* improves cancer awareness among Salvadoran families who attend the consulate for their legal needs. Through an on-site clinic for preventive health care, family members receive health screenings for chronic diseases and culturally-appropriate information through educational sessions, speakers, print and audiovisual materials. For example, patients who receive a screening for diabetes, hypertension or other disease risk factors will also have a one-on-one cancer education session which includes personalized cancer information and referral for cancer screening as appropriate for age and gender of the patient. Topics include cancer prevention, early detection and treatment for the most common types of cancer among Hispanics, as well as information on community programs that offer free or low-cost screenings for the underserved.

## Limitations

These data should be interpreted with caution. Although BRFSS and YRBSS data in this report are suppressed if less than 50 persons, the relatively small numbers of responses presented here may result in variations due to small numbers alone. The risk factor data, however, can give a general indication of the cancer risk behaviors among Latinos relative to non-Hispanic whites and non-Hispanic blacks. Also, cancer incidence and mortality data for U.S. Hispanics cannot easily be extrapolated to the experiences of Hispanics within the South Atlantic Division states because of regional and cultural differences.

Beginning in 1995, cancer rates can now be generated by site and sex for most of the U.S. population stratified by ethnicity and three major race groups. Broad racial and ethnic groupings, however, may mask wide variations in the cancer burden for specific high-risk populations defined by cultural characteristics such as urbanicity, economic deprivation and recent immigration.<sup>10</sup>

Identification of ethnic populations is still inconsistent and underreported in medical records and death certificates. In addition to the suspected underrepresentation of the Hispanic/Latino population in U.S. Census data, anecdotal reports are that Hispanic immigrants may return to their native country after a diagnosis of cancer, which would result in underreporting of cancer deaths among Latinos.<sup>10</sup>

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